

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
are retained by the hospital or attending physician.  
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3819

## CERTIFICATE OF DEATH

03762

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HIS LATE HOME</u>		d. STREET ADDRESS <u>1 MAIN ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>M</u> Last <u>BECKETT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-20-1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafarer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES BECKETT</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE FIELDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MARY BECKETT</u> Address <u>CHANCE MA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X cerebral thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3-1-60</u> , 19____, to <u>3-4-60</u> , 19____, that I last saw the deceased alive on <u>3-4-60</u> , 19____, and that death occurred at <u>3A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D. <u>Princess Anne, Maryland</u> <u>3-7-60</u> PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR-8-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. CHARLES</u>		22d. LOCATION (City, town, or county) <u>CHANCE</u> (State) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Webster</u> ADDRESS <u>Deal Island</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

3816

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03763

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Crisfield</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mariners Road</b>				d. STREET ADDRESS <b>1 Mariners Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LAURA</b> Middle <b>HOLLAND</b> Last <b>BLADES</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1871</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Holland</b>				14. MOTHER'S MAIDEN NAME <b>Julia Lankford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Avalon Riggins--E. Chesapeake Ave.--Crisfield</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile Degeneration</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> 19 <b>53</b> to <b>3/5</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> 19 <b>60</b> and that death occurred at <b>8:00 P.M.</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>A. N. Barr</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/7/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. N. Barr, M.D.</b>				22d. ADDRESS <b>Main St.--Crisfield, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 8, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mariners Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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Agency

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH  
 03764

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b> c. LENGTH OF STAY IN 1b <b>Lifetime</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b> d. STREET ADDRESS <b>R. F. D.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ASBURY</b> Last <b>CLUFF</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1873</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Marion Station, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>George I. Cluff</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Coulbourn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Thomas Riggin--Marion Station, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dil? Heart Arrhythmia</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Dil? reg. Ch. reg. arrhythmia</b> DUE TO (c) <b>Gen. Arterio Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gen. Arterio Sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1957</b> to <b>Mar. 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>Mar. 6, 1960</b> , and that death occurred at <b>2:35 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>George C. Coulbourn</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>George C. Coulbourn, M.D.</b>				22d. ADDRESS <b>Marion Station, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 8, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rehobeth Baptist Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rehobeth, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 14 60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. ...</b>	

10000

STATE OF NEW YORK  
CERTIFICATE OF DEATH

3850

Decedent's Name: [Illegible] Date of Death: [Illegible]

Place of Death: [Illegible] Cause of Death: [Illegible]

Age at Death: [Illegible] Sex: [Illegible]

Marital Status: [Illegible] Occupation: [Illegible]

Signature of Physician: [Illegible]

Signature of Coroner: [Illegible]

Signature of Registrar: [Illegible]

Signature of [Illegible]: [Illegible]

Signature of [Illegible]: [Illegible]

Signature of [Illegible]: [Illegible]

Signature of [Illegible]: [Illegible]

Signature of [Illegible]: [Illegible]

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Signature of [Illegible]: [Illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03765

Reg. Dist. No.

3821

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oriole</u>		c. LENGTH OF STAY IN 1b <u>59 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oriole</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle Last <u>Davis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1900</u>		9. AGE (In years last birthday) <u>59 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryl and</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Davis</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr Thomas Davis Oriole, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis, cephalitis,</u> DUE TO (c) <u>Prostatic Hypertrophy -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>0</u> <u>Month</u> <u>month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epileptic for years -</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.H. Johnson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 25-1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-27-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oriole, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CLERGY	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF BURIAL PLACE		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
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97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO BE retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03766

3822

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>C.</b> Middle <b>Griffith</b> Last		4. DATE OF DEATH Month <b>Mar.</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1881</b>
9. AGE (In years and birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William J. Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Clayville</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-36-1752</b>	
17. INFORMANT <b>Mrs. Annie Griffith Princess Anne, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>generalized and coronary arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1958</b> , 19____, to <b>3-18-60</b> , 19____, that I last saw the deceased alive on <b>3-18-60</b> , 19____, and that death occurred at <b>7A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Princess Anne, Md.</b> DATE SIGNED <b>3-20-60</b>			
ACTUAL SIGNATURE <b>Everett C. Sutter</b>		M.D. <b>Princess Anne, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Hannon</b>		ADDRESS <b>Princess Anne, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hannon</b>	

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
OFFICE OF THE STATE HEALTH OFFICER  
DIVISION OF VITAL RECORDS  
SAN FRANCISCO, CALIF.

3882

Married

Married

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3823

## CERTIFICATE OF DEATH

Reg. Dist. No.

03767

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>88 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SENESA HORSEY</b>		4. DATE OF DEATH Month Day Year <b>MARCH 3 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 4, 1871</b>
9. AGE (In years last birthday) <b>88</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDGAR W. HORSEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. HICKMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>EWELL DAUGHERTY</b>		Address <b>CRISFIELD, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia following varicella infection 3 weeks</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 10, 1960</b> to <b>Mar. 3, 1960</b> that I last saw the deceased alive on <b>MARCH 3, 1960</b> , and that death occurred at <b>12 NOON</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D.		ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 6, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAR 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

IN SENATE

1893

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

AT ITS SESSION ON JANUARY 10, 1893

ALBANY: J. B. LEECH, STATE PRINTER, 1893.

THE COMMISSIONER OF THE LAND OFFICE

ALBANY, N. Y.

1893

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THE COMMISSIONER OF THE LAND OFFICE

ALBANY, N. Y.

1893

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3818

CERTIFICATE OF DEATH

03768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>				c. LENGTH OF STAY IN 1b <u>5 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>W.</u> Last <u>Ingersol</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Ingersol</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Fred Taylor, Eden, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Progressive spinal muscular atrophy</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-6-60</u> , 19 <u>  </u> , to <u>3-13-60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>3-12-60</u> , 19 <u>  </u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D. <u>Princess Anne, Maryland</u> <u>3-14-60</u> PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	





3824

## CERTIFICATE OF DEATH

03769

Reg. Dist. No. 7682

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smith Island</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smith Island</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ewell</b>				d. STREET ADDRESS <b>Ewell</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLOTTE GOULD JONES</b>				4. DATE OF DEATH <b>March 29 30, 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1888</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ewell, Smith Island, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Andrew C. Tyler</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Messick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-26-3297</b>		17. INFORMANT <b>Caleb Jones, Sr.—Ewell, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>33/X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 10, 1959</b> , to <b>March 30, 1960</b> , that I last saw the deceased alive on <b>March 30, 1960</b> , and that death occurred at <b>5:17 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Ewell, Smith Island, Maryland</b> <b>March 30, 1960</b>							
ACTUAL SIGNATURE <b>William H. Heffner, M.D.</b>				PHYSICIAN'S NAME (Type) <b>William H. Heffner, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>April 3, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ewell Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons—Crisfield, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
22d. LOCATION (City, town, or county) (State) <b>Ewell, Smith Island, Md.</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
3825  
CERTIFICATE OF DEATH

03770

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN Tn <b>Lifetime</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		d. STREET ADDRESS <b>R. F. D. Lawsonia</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D. Lawsonia</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>MANUEL</b> Last <b>STERLING LEE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1959</b>	
9. AGE (In years lost birthday) <b>0</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>6</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
11. BIRTHPLACE (State or foreign country) <b>Somerset Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Linwood Lee</b>		14. MOTHER'S MAIDEN NAME <b>Peggy Sterling</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Linwood Lee--R.F.D. Lawsonia--Crisfield, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b></b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>3/10/60</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3/10/60</b> to <b>3/10</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>3/10</b> 19 <b>60</b> , and that death occurred on <b>9 A.M.</b> from the causes and on the date stated above.				
22a. SIGNATURE <b>Sarah M. Peyton</b> M.D.		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M.D.</b>		22d. ADDRESS <b>Main St.--Crisfield, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 11, 1960</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 14 '60</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>				

2219278XV3

CERTIFICATE OF DEATH

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Decem-ber

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3826

## CERTIFICATE OF DEATH

Reg. Dist. No.

03771

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARION STATION</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>				d. STREET ADDRESS <b>R #1, Box 238</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEFFRY</b> Middle <b>Thomas</b> Last <b>MACK</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-24-59</b>		9. AGE (In years last birthday) yrs. <b>4</b> Months <b>9</b> Days <b>9</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JESSE RICHARDSON</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES MACK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT Address <b>FRANCES MACK, MARION, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b> DUE TO <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3:14</b> , 19 <b>60</b> , to <b>3:14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3:14</b> , 19 <b>60</b> , and that death occurred at <b>7:35PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b></b>							
ACTUAL SIGNATURE <b>Sarah M. Peyton</b> M.D. <b>MAIN STREET</b>							
PHYSICIAN'S NAME (Type) <b>SARAH M. PEYTON, M.D.</b> <b>CRISFIELD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 6, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAR 9 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

2079 202XV5

3823

CERTIFICATE OF DEATH

DATE OF DEATH 1 DAY

AGE 100 YEARS

SEX MALE

DATE OF BIRTH 10-10-18

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH 10-10-18

10-10-18

10-10-18

10-10-18



3827

## CERTIFICATE OF DEATH

Reg. Dist. No.

03772

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>32 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMO. HOSP.</b>		d. STREET ADDRESS <b>1 MAIN STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES C STERLING, JR.</b>		4. DATE OF DEATH Month Day Year <b>MARCH 16 1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-1927</b>
9. AGE (In years last birthday) <b>32</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLINTON STERLING</b>		14. MOTHER'S MAIDEN NAME <b>PAULINE LAWSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>215-20-0154</b>	
17. INFORMANT <b>ELsie STERLING, CRISFIELD, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Esophagus &amp; Hemorrhage</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Biliary Cirrhosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>2 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/27</b> , 19 <b>52</b> to <b>3/16</b> , 19 <b>60</b> that I last saw the deceased alive on <b>MARCH 16</b> , 19 <b>60</b> , and that death occurred at <b>11:15 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. N. Barr, M.D.</b>		ADDRESS (Street, city or town, state) <b>MAIN STREET</b> DATE SIGNED <b>9/17/60</b>	
PHYSICIAN'S NAME (Type) <b>A. N. BARR, M.D.</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 19, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAR 21 1960</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Robert E. [illegible]</b>			

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TO SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO THE CREDIT OF  
JAMES M. HENRY, JR.  
\$100.00  
DATE 1-1-1937  
BY J. H. HENRY, JR.  
J. H. HENRY, JR.  
J. H. HENRY, JR.

Between JAMES M. HENRY, JR.  
and J. H. HENRY, JR.  
\$100.00  
DATE 1-1-1937  
BY J. H. HENRY, JR.

Between JAMES M. HENRY, JR.  
and J. H. HENRY, JR.  
\$100.00  
DATE 1-1-1937  
BY J. H. HENRY, JR.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03773

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>SOMERSET</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>SOMERSET</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>			c. LENGTH OF STAY IN 1b <u>LIFETIME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>39 CRISFIELD</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AT HIS HOME</u>				d. STREET ADDRESS <u>1 MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>FLETCHER</u> <span style="float: right;">First Middle Last</span>				<b>4. DATE OF DEATH</b> <u>MARCH 22 1960</u> <span style="float: right;">Month Day Year</span>			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEB. 16 - 1885</u>	
<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SEAFOOD</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND - U.S.A.</u>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>BENJAMIN THOMAS</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>ELLEN CROCKETT</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>				<b>17. INFORMANT</b> <u>OLIVER THOMAS - CRISFIELD, MD</u> <span style="float: right;">Address</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Died during sleep</u> <u>434.4</u> DUE TO <u>Natural causes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Legs swollen - Organic Heart Disease</u> (c)						INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>CRISFIELD</u>		<b>20f. City or town</b> (County) (State) <u>CRISFIELD</u> <u>MD</u>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Wm H. Coulbourn</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>Wm H. Coulbourn</u>				<b>DATE SIGNED</b> <u>3-23-60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>MAR. 24 - 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CRISFIELD</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>CRISFIELD</u> <u>MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>L. S. Webster Crisfield, Md</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAR 28 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

